HIT Policy Committee

Information Exchange Workgroup

January 25, 2010

9:00 a.m. – 1:00 p.m. (Eastern)

HHS Humphrey Building, Room 505A

200 Independence Ave, SW

Washington, DC 20201

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Peninsula Regional Medical Center, located in Salisbury on Maryland's Eastern Shore has a long standing history of providing the highest quality, most technologically advanced care to the communities that we serve. The 358 bed, tertiary care facility and regional trauma center is nationally recognized for quality and outcomes by the Joint Commission, HealthGrades and others. Supporting the skilled team responsible for these leading clinical and quality outcomes is an infrastructure of advanced clinical information technology. Recognizing the role that HIT and the electronic medical record would need to play to achieve the organizations goals for quality and patient safety, the medical center has made a substantial investment in the technology over the past decade. Today Peninsula Regional is ranked among the top 2% in the nation achieving Stage 6 on the HIMSS Analytics EMR Model indicative of the level of clinical system integration and use of advanced clinical decision support. Chief among these capabilities are the technologies supporting the *closed-loop medication management cycle*. Utilizing CPOE, advanced Pharmacy management systems, robotic dispensing and cabinet storage and point of administration scanning of individually bar-coded medications the medical center has been a leader in leveraging the successful use of information technology to improve quality and safety in the administration of medications to our patients.

Despite our successes, challenges remain, among them the development of a manageable and comprehensive process for medication reconciliation. In spite of the national attention placed on the importance of an accurate patient medication list and the reconciliation of said list at transitions in care – much work remains. The medical center has expended considerable resources over the past three years (in excess of $500K and dedicating 5 FTE's in support) to establish processes utilizing available technology to support a comprehensive approach for the reconciliation of medications throughout a patient's encounter. Through the course of these efforts much has been learned regarding the

challenges, inconsistencies in practice, perception and sense of responsibility as they relate to medication reconciliation. Today the medical center provides our clinicians with a patient's home medication list as reported by the patient and patient medication history as reconciled at the time of a transition in care from the medical center. Accuracy and completeness of the information contained within the record has improved. We have moved from a process in which medication information may have resided with as many as five disparate sources to one. Culture is shifting as physicians have an improved understanding of the importance of the process and their active role in supporting the review and reconciliation.

Opportunities for improvement remain. While a patient's medication history is available for review and update at the point of an encounter with the medical center, the completeness and accuracy of information in that record remains largely dependent upon the patient as the historian. Despite efforts to educate and raise awareness within our community, limited progress has been made in helping our patients understand their inherent responsibility to play an active role in the maintenance of an accurate and complete history comprised of medication name, dose, route, frequency, duration and last dose. Today, the admission reconciliation process is without the benefit of an external, comprehensive source of historic content reflecting both the prescribing and dispensing history associated with the patient beyond the medical center campus. While technology continues to advance in this area the ability of disparate systems to leverage access to national repositories remains elusive. Beyond the technology are the challenges – process, resource and cultural, to be overcome both within and beyond the walls of individual organizations and provider practices. The meaningful use guidelines for reconciliation of medications propose that hospitals and physicians are to "perform medication reconciliation at relevant encounters and each transition of care." The expectation of reconciliation at each transition of care raises a number of concerns; among them is the role of the specialty provider that does not reconcile medications outside of their scope of practice. As an example, an urologist has no concern or awareness of the use of lipid lowering agents. An expectation that they reconcile medications not pertinent to their practice may be misleading and dangerous. Access and adoption of an integrated solution within a community will remain problematic. Incentives may not be adequately aligned and given associated interdependencies an organization or individual provider may be penalized given the inability or choice of an affiliate (i.e. physician, nursing home, rehab-center) to participate in the process and/or adopt the technology. Given our experience - the availability, capability and the integration of required systems and the processes within which they are used to support the referenced expectation for meaningful use of a technology supported medication reconciliation solution is unlikely in the near to mid-term within the typical community. In our view the initial bar is set to high.

Paralleling the medical center's efforts to support the development of a unifying solution for medication reconciliation are efforts for the adoption of e-prescribing within the community. Utilizing the Peninsula Regional sponsored service MyPenCare.org , 84 community providers now employ the use of e-prescribing within their respective practice with an emphasis in Family Practice, Internal Medicine and Pediatrics. The capability is part of an integrated solution providing patients with a personal health record and secure e-messaging with their provider. On average, 6,500 e-scripts are generated per month via the service. Feedback to date regarding the e-prescribing features is positive. The capability

has introduced providers to the benefits of e-prescribing and will serve as a bridge to their future adoption of an ambulatory EMR. There is clear recognition of improvements in efficiency and satisfaction of patient, provider, their staff and pharmacies within the region. The ability for the provider to access a comprehensive view of mediation history for the patient during the prescribing process has proven to be a powerful benefit and enticement for use of the technology as well. While not yet shared with the content housed within the medical center's medication information store, the foundations are being laid to bring the two information sources together providing a unified view spanning settings of care within the community. Until that time the process though improved, remains less than optimal. Additional barriers or challenges encountered are largely process in nature and a function of the rate and tolerance of provider adaptation to change. Finally, the current exclusion of the use of e-prescribing for controlled substances remains problematic requiring providers to employ dual processes if they should choose to attempt to incorporate the use of e-prescribing within their practice. Though the impact of the exclusion varies by specialty, in our experience as much as one-third of the prescriptions generated can be for controlled substances. In some specialties (i.e. surgical, pain-management) the limitation is much more significant greatly diminishing the interest or value the use of e-prescribing would bring to the provider given the impact on associated work processes. The inability to fully leverage the benefits validated through the use of e-prescribing by providers within the Greater Salisbury community – gains in efficiency, satisfaction and ultimately as a contributor to improved safety for the patient – must be extended to this group of medications.